THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3037.M5

MDR Tracking Number: M5-04-2557-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on April 15, 2004.

The IRO reviewed CPT Codes 97110, 99213, 99212-25, 97530, 97265, 97250, 97112, and 97140 that were denied based upon "U".

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

A maximum of 5 units per DOS of therapeutic exercises/therapeutic activities; 1 unit of joint mobilization per DOS; 1 unit of myofasical release per DOS; and one 99213 office visit per DOS are approved for the time period from 04/15/03 through 05/30/03 **were** found to be medically necessary. All therapeutic exercises/therapeutic activities in excess of 5 units per DOS for the time period from 04/15/03 through 05/30/03 and all services after 05/30/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for CPT Codes 97110, 99213, 99212-25, 97530, 97265, 97250, 97112, and 97140.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On June 25, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 97035 (3 units total) for dates of service 04/21/03 through 04/23/03 denied as "F". Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(a)(iii) reimbursement in the amount of $66.00 is recommended.

- CPT code 97032 (3 units total) for dates of service 04/21/03 through 04/23/03 denied as "F". Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(a)(iii) reimbursement in the amount of $66.00 is recommended.

- CPT Code 97112 (2 units total) for dates of service 10/17/03 and 10/27/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to Rule 134.202 and the Medicare Fee Schedule. Per Rule 134.202(b) and the Medicare Fee Schedule reimbursement in the amount of $66.82 ($26.73 x 125% = $33.41 x 2) is recommended.

- CP Code 97110 (4 units total) for dates of service 10/17/03 and 10/27/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to the Act and TWCC rules. Consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

- CPT Code 97530 (4 units total) for dates of service 10/17/03 and 10/27/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to Rule 134.202 and the Medicare Fee Schedule. Per Rule 134.202(b) and the Medicare Fee Schedule reimbursement in the amount of $131.84 ($26.37 x 125% = $32.96 x 4) is recommended.

- CPT Code 97140 (4 units total) for dates of service 10/17/03 and 10/27/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to Rule 134.202 and the Medicare Fee Schedule. Per Rule 134.202(b) and the Medicare Fee Schedule reimbursement in the amount of $123.30 ($24.72 x 125% = $30.90 x 4) is recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 04/15/03 through 05/30/03, 10/17/03 and 10/27/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 4th day of November 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 6/23/04

TWCC Case Number:
MDR Tracking Number: M5-04-2557-01
Name of Patient:
Name of URA/Payer: Cotton D. Merritt, DC
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: Cotton D. Merritt, DC (Treating or Requesting)

June 2, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY
Patient received extensive physical medicine treatments after injuring his cervical and lumbar spine when he fell from a scaffold on ___.

REQUESTED SERVICE(S)
97110-Therapeutic exercises, 99213, 99212-25-OV, 97530-Therapeutic Activities, 97265-Joint Mobilization, 97250-Myofacial Release, 97112-Neuromuscular re-education, 97140-Manual therapy technique from 04/15/03 through 12/17/03 (excluding 10/17/03 and 10/27/03).

DECISION
A maximum of 5 units per DOS of therapeutic exercises/therapeutic activities; 1 unit of joint mobilization per DOS; 1 unit of myofascial release per DOS; and one 99213 OV per DOS are approved for the time period from 04/15/03 through 05/30/03.

All therapeutic exercises/therapeutic activities in excess of 5 units per DOS for the time period from 04/15/03 through 05/30/03 and all services after 5/30/03 are denied.

RATIONALE/BASIS FOR DECISION

Based on the history and examination of this patient, it would be reasonable to conclude that 6 weeks of treatment would be

medically necessary. However, once it was determined that the treatment was not relieving the effects of the injury, was not promoting recovery and was not enhancing the ability of the patient to return to work, the treatment was no longer medically necessary. The patient's non-response to care is documented by the daily treatment notes that indicate that neither the patient's cervical or lumbar ranges of motion significantly improved from 04/15/03 through 05/30/03.

More importantly, the medical records submitted fail to document that chiropractic spinal adjustments were performed at any time.

According to the AHCPR[1] guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain.

[1] Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.